N432 Labor and Delivery Concept map template

Medications

(see bigger version on last page)
(Vallerand, 2021).

Name:	Cefazolin	Clinda
Class:	T: Anti-infectives P: First generation cephalosporins	T: Anti-in
Reason for taking:	Given after invasive surgery to prevent infection.	Given after inva prevent i
Key nursing assessments:	1. Assess for infection (vitals, wound appearance, cultures if needed, WBC count) 2. Observe for signs of allergic reaction (anaphylaxis, rash, wheezing.) 3. Monitor bowel function (look for diarrhea, abdominal pain, cramping, fever.)	1. 2. 3.

Docusate	Glycopyrrolate	Keto
T: Laxative P: Stool softener	T: Antispasmodics P: Anticholinergics	T: nonsteroical anti-inflammatory agent nonopioid analgesic P: Pyrroziline carboxylic acid
Prevention of constipation and straining in patients who just has surgery.	Inhibits salivation and excessive respiratory secretions when given postoperatively.	Short term pain and anti-inflammatory management.
1. Assess for abdominal distention, presence of bowel sounds, and usual pattern of bowel function. 2. Assess color, consistency, and amount of stool produced. 3. Observe for signs of dehydration (promotes	1. Assess for toxicity (neostigmine is the antidote). 2. Assess heart rate, BP, and RR before and periodically during therapy. 3. Assess for abdominal distention and auscultate bowel sounds (may cause constipation)	1. 2. 3.

Demographic Data

Admitting diagnosis: Term pregnancy at 39 weeks

Secondary diagnosis: Repeat C-section

Age of client: 28 years old

Weight in kgs: 83.8 kg

Allergies: Chlorhexidine topical, cyclobenzaprine, Macrobid, penicillin's, red dye

Date of admission: 8/31/2022

Support person present: Husband, Austin York

Presentation to Labor and Delivery

Electronic Fetal Heart Monitoring: (At the beginning and the end of shift.)

Baseline EFH: N/A

I do not have access to this. (We talked about it)

Variability: N/A

Accelerations: N/A

Decelerations: N/A

Contractions: N/A

-frequency: N/A

-length: N/A

-strength: N/A

-patient's response: N/A

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Patient is a 28-year-old female who presented to the Labor and delivery unit on 8/31/2022 for a scheduled repeat C-section. The patient is 39 weeks' gestation and denies any contractions. The patient requested to be sterilized and us aware if the risk of regret. The patient has had two previous c-sections and one abortion due to fetal death. The patient states that the fetus is very active and feels as if the fetus has "dropped." Patients' vital signs are within normal limits. IV lines accessed and preparation for c-section begins.

Prenatal & Current Lab Values/Diagnostics

- Prenatal: (8/8/22)
  - Hgb: 10.7 (L)
  - Hct: 32.0 (L)
  - MCV: 78.1 (L)
  - MHC: 26.2 (L)
- Current:
  - Hgb: 10.0 (L)
  - Hct: 29.6 (L)
  - MCV: 74.8 (L)
  - MHC: 25.2 (L)
- Normal limits:
  - Hgb: 11.3-15.2
  - Hct: 33.2-45.3
  - MCV: 79.5-98.1
  - MHC: 27.0-34.2
- Hgb: Low Hgb indicates iron deficiency anemia due to pregnancy and puts the mother and child at risk for premature birth.
- Hct: Low Hct indicates iron deficiency anemia due to pregnancy and puts the mother and child at risk for premature birth.
- MVC: Low MCV indicates iron deficiency anemia or may be related to the patient's chronic illness.
- MCH: Low MCH indicates iron deficiency anemia due to pregnancy and puts the mother and child at risk for premature birth.

(Van & Bladh, 2017).

Medical History

Prenatal History: G42012, prenatal vitamins taken daily, OBGYN appointments regularly per gestational week, all prenatal labs WNL.

Previous Medical History: History of seizure disorder, anxiety, depression, ANCA+, vasculitis, hypotension, OCD, and nicotine use of 3mg.

Surgical History: Removal of wisdom teeth (2012), two previous C-sections (2017/2021), ectopic laparotomy (2021).

Family History: Mother: Addison's disease, thyroid cancer

Father: COPD

Social History: Vaping (3 mg) during pregnancy, occasional alcohol use before pregnancy, denies any drug use, highest level of education: high school, stay at home mother, regular diet at home.

Active Orders

- Urinary indwelling catheter insertion, PRN
  - Catheter care, PRN
    - (For possible urinary retention)
- Straight catheter, PRN
  - (For possible urinary retention)
- External tocodynamometers, Continuous per hospital policy
  - (Measures the frequency, duration, and strength of contractions)
- Fetal heart monitoring, Continuous per hospital policy
  - (Records FHR)
- Intermittent pneumonic compression devices, Continuous
  - (Increase blood flow/decreases risk of blood clots)
- NPO, Continuous
  - (Pt should not eat or drink in case of emergency surgery/intubation. Increases the risk of aspiration.)
- Urine culture, Once
  - (Check for GBS or other infections that may cause harm to mother or fetus)
- CBC w/ diff, Once
  - (Estimates blood loss after surgery/delivery, and may indicate if an infection is present)
- Blood gas sample, Once
  - (Identifies infants at risk for neonatal encephalopathy)
- Vital signs, Q4 hours
  - (Ensures the ability to identity and intervene for those at risk for clinical deterioration and preventable death)
- Weight, daily
  - (Important for prescribing medications, assessing fluid balances, and nutrition.
- Ambulate day of surgery
  - (Helps reduce the use of pain medication, increases risk of compliance to breast feeding and oral intake, decreases risk of blood clots)

Revised 5/10/22

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Stages of Labor
Stage 1 **N/A**
Stage 2 **N/A**

Stage 3
N/A

Nursing Diagnosis 1	Nursing Diagnosis 2	Nursing Diagnosis 3
Rationale for the Nursing Diagnosis Risk for infection related to invasive cesarean section surgery as evidence by compromised immune system.	**Rationale for the Nursing Diagnosis** Risk for deficient fluid volume related to blood loss during surgery as evidence by low hemoglobin and hematocrit levels.	**Rationale for the Nursing Diagnosis** Risk for injury related to trauma to tissue as evidence by cauterization and suturing of surgical wound.
Interventions **Intervention 1:** Strictly adhere to preoperative care per protocol; according to scrub protocol. **Rationale:** Decreases the risk of skin contaminants entering the operative site, reducing infection (Phelps, 2020). **Intervention 2:** Emphasize the importance of	**Interventions** **Intervention 1:** Assess the patient's intake and output for at least 24 hours. **Rationale:** Recording fluid volume will show signs of fluid retention or fluid volume deficit (Phelps, 2020). **Intervention 2:** Assess client's respirations, blood	**Interventions** **Intervention 1:** Assess and record first voiding patterns after surgery. **Rationale:** Assessing bladder and bowel functions after surgery ensure there is no damage. Not being about to void by themselves indicates a post-surgical problem (Phelps, 2020).

taking all the prescribed antibiotics even if they feel better or do not have symptoms of infection. **Rationale:** Premature discontinuation of antibiotic medications may cause reinfection or antibiotic resistance (Phelps, 2020).	pressure, pulse, and temperature every 15 minutes for the first hour, every 30 minutes for the next two hours, and every hour for the next 4 hours, then every 4 hours. **Rationale:** Decreased blood pressure and weak thready pulse are common signs of fluid volume deficit (Phelps, 2020).	**Intervention 2:** Assess the surgical incision every 8 hours post-surgery. **Rationale:** The surgical wound should be assessed to look for signs of infection such as erythema or purulent discharge (Phelps, 2020).
Evaluation of Interventions Patient goals are met. The patient remains free from infection and is recovering at a normal rate.	**Evaluation of Interventions** Patient goals are met. The patient was outputting close to the number they were inputting, and vital signs were all within normal limits.	**Evaluation of Interventions** The patient goals are met. The patient's incision was minimal and shows no signs or infections.

References (3):

Phelps, L. L. (2020). *Sparks & Taylor's nursing diagnosis reference manual*. Wolters Kluwer.

Vallerand, A. H., & Sanoski, C. A. (2021). Davis's drug guide for Nurses. F.A. Davis Company

Van, A. M., & Bladh M. L. (2017). *Davis's comprehensive handbook of laboratory & diagnostic tests with nursing implications.* F.A. Davis Company.

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Medications:

Name:	Cefazolin	Clindamycin	Docusate	Glycopyrrolate	Ketorolac
Class:	T: Anti-infectives P: First generation cephalosporins	T: Anti-infectives P: N/A	T: Laxative P: Stool softener	T: Antispasmodics P: Anticholinergics	T: nonsteroidal anti-inflammatory agent nonopioid analgesic P: Pyrroziline carboxylic acid
Reason for taking:	Given after invasive surgery to prevent infection.	Given after invasive surgery to prevent infection.	Prevention of constipation and straining in patients who just has surgery.	Inhibits salivation and excessive respiratory secretions when given postoperatively.	Short term pain and anti-inflammatory management.
Key nursing assessments:	1. Assess for infection (vitals, wound appearance, cultures if needed, WBC count) 2. Observe for signs of allergic reaction (anaphylaxis, rash, wheezing.) 3. Monitor bowel function (look for diarrhea, abdominal pain, cramping, fever.)	1. Assess for infection (vitals, wound appearance, cultures if needed, WBC count) 2. Monitor bowel function (look for diarrhea, abdominal pain, cramping, fever.) 3. Assess patient for hypersensitivity (rash, urticaria)	1. Assess for abdominal distention, presence of bowel sounds, and usual pattern of bowel function. 2. Assess color, consistency, and amount of stool produced. 3. Observe for signs of dehydration (promotes incorporation of water into stool)	1. Assess for toxicity (neostigmine is the antidote). 2. Assess heart rate, BP, and RR before and periodically during therapy. 3. Assess for abdominal distention and auscultate bowel sounds (may cause constipation)	1. Assess for rash periodically during therapy. 2. Monitor BP frequently (may cause fluid retention) 3. Assess pain (note location, type, and intensity)